B. Additional APC Changes Resulting from BIPA Provisions

1. Coverage of Glaucoma Screening

Section 102 of the BIPA amended section 1861(s)(2) of the Act to provide payment for glaucoma screening for eligible Medicare beneficiaries, specifically, those with diabetes mellitus or a family history of glaucoma, and certain other individuals found to be at high risk for glaucoma as specified by our rulemaking. The implementation of this provision is discussed in detail in a separate proposed rule concerning the revisions in the physician payment policy for CY 2002.

In order to implement section 102 of BIPA, we have established two new HCPCS codes for glaucoma screening:

G0117 - Glaucoma screening for high risk patients furnished by an ophthalmologist or optometrist.

G0118 - Glaucoma screening for high risk patients furnished under the direct supervision of an ophthalmologist or optometrist.

We are proposing to assign the glaucoma screening codes to APC 0230, Level I Eye Tests. We further propose to instruct our fiscal intermediaries to make payment for

glaucoma screening only if it is the sole ophthalmologic service for which the hospital submits a bill for a visit. That is, the services included in glaucoma screening (a dilated eye examination with an intraocular pressure measurement and direct opthalmoscopy or slit-lamp biomicroscopy) would generally be performed during the delivery of another opthalmologic service that is furnished on the same day. If the beneficiary receives only a screening service, however, we would pay for it under APC 0230.

2. APCs for Contrast Enhanced Diagnostic Procedures

Section 430 of the BIPA amended section 1833(t)(2) of the Act to require the Secretary to create additional APC groups to classify procedures that utilize contrast agents separately from those that do not, effective for items and services furnished on or after July 1, 2001. On June 1, 2001, we issued a Program Memorandum, Transmittal A-01-73, in which we made numerous coding and grouping changes to implement this provision. (This transmittal can be found at www.hcfa.gov/pubforms/transmit/AO173.pdf) We removed the radiological procedures whose descriptors included

either "without contrast material" or "without contrast material followed by contrast material" from APC groups 0282, Level I, Computerized Axial Tomography; APC 0283, Level II, Computerized Axial Tomography; and APC 0284, Magnetic Resonance Imaging. As a result, APCs 0283 and 0284 now include only imaging procedures that are performed with contrast materials. Additionally, reconfigured APC 0282 no longer includes radiological procedures that use contrast agents.

Effective for items or services furnished on or after July 1, 2001, we created six new APC groups for the procedures removed from APCs 0282, 0283, and 0284, as shown below. (Effective October 1, 2001, we will eliminate APC 0338. Refer to Transmittal A-01-73 for a detailed description of this change.) For services furnished on or after July 1, 2001 and before January 1, 2002, the payment rates for the new imaging APCs are the same as those associated with the APCs from which the procedures were moved. In this proposed rule, the weights for the new APCs are recalibrated based on the data we are using to set the weights for 2002.

Table 1—APC Groups Reconfigured to Separate Imaging Procedures That Use Contrast Material from Procedures That Do Not Use Contrast Material

APC	SI	APC Title
0282	S	Miscellaneous Computerized Axial Tomography
0283	S	Computerized Axial Tomography with Contrast
0284	S	Magnetic Resonance Imaging and Angiography with Contrast
0332	S	Computerized Axial Tomography w/o Contrast
0333	S	CT Angio and Computerized Axial Tomography w/o Contrast followed by with Contrast
0335	S	Magnetic Resonance Imaging, Temporomandibular Joint
0336	S	Magnetic Resonance Angiography and Imaging without Contrast
0337	S	Magnetic Resonance Imaging and Angiography w/o Contrast followed by with Contrast
0338	S	Magnetic Resonance Angiography, Chest and Abdomen with or w/o Contrast

The HCPCS codes that are reassigned to the new imaging APCs in this proposed rule are as follows:

APC	HCPCS	SI	Short Descriptor
0282	76370	S	CAT scan for therapy guide
	76375	S	3d/holograph reconstr add-on
	76380	S	CAT scan for follow-up study
	G0131	S	Ct scan, bone density study
	G0132	S	Ct scan, bone density study
0283	70460	S	Ct head/brain w/dye
	70481	S	Ct orbit/ear/fossa w/dye
	70487	S	Ct maxillofacial w/dye
	70491	S	Ct soft tissue neck w/dye
	71260	S	Ct thorax w/dye
	72126	S	Ct neck spine w/dye
	72129	S	Ct chest spine w/dye
	72132	S	Ct lumbar spine w/dye
	72193	S	Ct pelvis w/dye
	73201	S	Ct upper extremity w/dye
	73701	S	Ct lower extremity w/dye
	74160	S	Ct abdomen w/dye
	76355	S	CAT scan for localization
	76360	S	CAT scan for needle biopsy
0284	70542	S	MRI orbit/face/neck w/dye
	70545	S	Mr angiography head w/dye
	70548	S	Mr angiography neck w/dye
	70552	S	MRI brain w/dye
	71551	S	MRI chest w/dye
	72142	S	MRI neck spine w/dye
	72147	S	MRI chest spine w/dye
	72149	S	MRI lumbar spine w/dye
	72196	S	MRI pelvis w/dye
	73219	S	MRI upper extremity w/dye
	73222	S	MRI joint upr extrem w/dye
	73719	S	MRI lower extremity w/dye
	73722	S	MRI joint of lwr extr w/dye
	74182	S	MRI abdomen w/dye
	75553	S	Heart MRI for morph w/dye
	C8900	S	MRA w/cont, abd
	C8903	S	MRI w/cont, breast,uni
	C8906	S	MRI w/cont, breast, bi
	C8909	S	MRA w/cont, chest

	C8912	S	MRA w/cont, lwr ext
0332	70450	S	CAT scan of head or brain
	70480	S	Ct orbit/ear/fossa w/o dye
	70486	S	Ct maxillofacial w/o dye
	70490	S	Ct soft tissue neck w/o dye
	71250	S	Ct thorax w/o dye
	72125	S	Ct neck spine w/o dye
	72128	S	Ct chest spine w/o dye
	72131	S	Ct lumbar spine w/o dye
	72192	S	Ct pelvis w/o dye
	73200	S	Ct upper extremity w/o dye
	73700	S	Ct lower extremity w/o dye
	74150	S	Ct abdomen w/o dye
0333	70470	S	Ct head/brain w/o&w dye
	70482	S	Ct orbit/ear/fossa w/o&w dye
	70488	S	Ct maxillofacial w/o&w dye
	70492	S	Ct sft tsue nck w/o & w/dye
	70496	S	Ct angiography, head
	70498	S	Ct angiography, neck
	71270	S	Ct thorax w/o&w dye
	71275	S	Ct angiography, chest
	72127	S	Ct neck spine w/o&w dye
	72130	S	Ct chest spine w/o&w dye
	72133	S	Ct lumbar spine w/o&w dye
	72191	S	Ct angiograph pelv w/o&w dye
	72194	S	Ct pelvis w/o&w dye
	73202	S	Ct uppr extremity w/o&w dye
	73206	S	Ct angio upr extrm w/o&w dye
	73702	S	Ct lwr extremity w/o&w dye
	73706	S	Ct angio lwr extr w/o&w dye
	74170	S	Ct abdomen w/o&w dye
	74175	S	Ct angio abdom w/o&w dye
	75635	S	Ct angio abdominal arteries
0335	70336	S	Magnetic image, jaw joint
	75554	S	Cardiac mri/function
	75555	S	Cardiac mri/limited study
	76390	S	Mr spectroscopy
	76400	S	Magnetic image, bone marrow
0336	70540	S	MRI orbit/face/neck w/o dye

	70544	S	Mr angiography head w/o dye
	70547	S	Mr angiography neck w/o dye
	70551	S	MRI brain w/o dye
	71550	S	MRI chest w/o dye
	72141	S	MRI neck spine w/o dye
	72146	S	MRI chest spine w/o dye
	72148	S	MRI lumbar spine w/o dye
	72195	S	MRI pelvis w/o dye
	73218	S	MRI upper extremity w/o dye
	73221	S	MRI joint upr extrem w/o dye
	73718	S	MRI lower extremity w/o dye
	73721	S	MRI joint of lwr extre w/o d
	74181	S	MRI abdomen w/o dye
	75552	S	Heart MRI for morph w/o dye
	C8901	S	MRA w/o cont, abd
	C8904	S	MRI w/o cont, breast, uni
	C8910	S	MRA w/o cont, chest
	C8913	S	MRA w/o cont, lwr ext
0337	70543	S	MRI orbt/fac/nck w/o&w dye
	70546	S	Mr angiograph head w/o&w dye
	70549	S	Mr angiograph neck w/o&w dye
	70553	S	MRI brain w/o&w dye
	71552	S	MRI chest w/o&w dye
	72156	S	MRI neck spine w/o&w dye
	72157	S	MRI chest spine w/o&w dye
	72158	S	MRI lumbar spine w/o&w dye
	72197	S	MRI pelvis w/o&w dye
	73220	S	MRI uppr extremity w/o&w dye
	73223	S	MRI joint upr extr w/o&w dye
	73720	S	MRI lwr extremity w/o&w dye
	73723	S	MRI joint lwr extr w/o&w dye
	74183	S	MRI abdomen w/o&w dye
	C8902	S	MRA w/o fol w/cont, abd
	C8905	S	MRI w/o fol w/cont, brst, uni
	C8908	S	MRI w/o fol w/cont, breast, bi
	C8911	S	MRA w/o fol w/cont, chest
	C8914	S	MRA w/o fol w/cont, lwr ext

Refer to Addendum A or Addendum B for the updated weights, payment rates, national unadjusted copayment, and

minimum unadjusted copayment that we are proposing for all of the procedures listed above.

C. Other Changes Affecting the APCs

1. Changes in Revenue Code Packaging

In the April 7, 2000 final rule, we described how, in calculating the per procedure and per visit costs to determine the median cost of an APC (and therefore its relative weight), we used the charges billed using the revenue codes that contained items that were integral to performing the procedure or visit (65 FR 18483). For example, in calculating the cost of a surgical procedure, we included charges for revenue codes such as operating room, treatment rooms, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and organ. For medical visit costs, we included charges for items such as medical and surgical supplies, drugs, and observation. The complete list of the revenue centers by type of APC group was printed in the April 7, 2000 rule (65 FR 18484).

In the November 13, 2000 interim final rule, we made some changes to the list of revenue codes to reflect the charges associated with implantable devices (65 FR 67806

and 67825). As we stated in that rule, charges included in revenue codes 274 (prosthetic/orthotic devices), 275 (pacemaker), and 278 (other implants) were not included in the initial APC payment rates because, before enactment of BBRA, we were proposing to pay these devices outside of the OPPS, and, after the enactment of the BBRA, it was not feasible to revise our database to include these revenue codes in developing the April 7, 2000 final rule. As discussed in the November 13, 2000 interim final rule, we were later able to incorporate these revenue codes in our database, and effective January 1, 2001, we updated the APC payment rates to reflect inclusion of this information.

We have continued to review and revise the list of revenue codes to be included in the database and we are proposing several changes to the list of revenue codes that are packaged with the costs used to calculate the proposed APC rates. Some of these changes reflect the addition of revenue codes and others are a further refinement of our methodology. The following are the specific changes we are proposing to make:

- Package additional revenue centers that may be used to bill for implantable devices (including durable medical

equipment (DME) and brachytherapy seeds) with surgical procedures. These additional centers are revenue codes 280 (oncology), 289 (other oncology), 290 (DME), and 624 (investigational devices).

- Package revenue codes 280, 289, and 624 with other diagnostic and radiology services.

- Package the revenue codes for medical social services, 560 (medical social services) and 569 (other medical social services). These services are not paid separately in the hospital outpatient setting but often constitute discharge-planning services if provided with an outpatient service.

- Package revenue code 637 (self-administered drug (insulin administered in an emergency diabetic coma)) with medical visits. Although this is a self-administrable drug, it is covered when administered as described.

- Remove revenue code 723 (circumcision) from the list of packaged revenue codes because circumcision is a payable procedure under OPPS and should not be packaged.

- Package revenue code 942 (education/training) with medical visits and the category of "All Other APC Groups."

Patient training and education are generally not paid as a separate service under Medicare, but may be included as part of an otherwise payable service such as a medical visit. We believe that training and education services generally occur as part of a medical visit or psychiatric service.

- Remove the revenue codes in the range of 890 through 899 (donor bank), as these are no longer valid revenue codes.

2. Special Revenue Code Packaging for Specific Types of Procedures

We are proposing that the same packaging used for surgical procedures be used for corneal tissue implant procedures in APC 0244, Corneal Transplant, except that organ acquisition revenue codes and the revenue codes used to bill implantable devices are not packaged with corneal implants.

There are certain other diagnostic procedures with CPT codes that are similar to surgical procedures. The cost of these procedures (HCPCS codes 92980-92996, 93501-93505, and 93510-93536) reflects both the revenue code packaging for ambulatory surgical center (ASC) and other surgery, as well

as the revenue code packaging for other diagnostic services.

A complete listing of the revenue codes that we are proposing in this rule and that we used for purposes of calculating median costs of services are shown below in Table 2.

TABLE 2

PACKAGED SERVICES BY REVENUE CODE

SURGERY

250	PHARMACY	290	DURABLE MEDICAL EQUIPMENT
251	GENERIC	370	ANESTHESIA
252	NONGENERIC	379	OTHER ANESTHESIA
257	NONPRESCRIPTION DRUGS	390	BLOOD STORAGE AND PROCESSING
258	IV SOLUTIONS	399	OTHER BLOOD STORAGE AND PROCESSING
259	OTHER PHARMACY	560	MEDICAL SOCIAL SERVICES
260	IV THERAPY, GENERAL CLASS	569	OTHER MEDICAL SOCIAL SERVICES
262	IV THERAPY/PHARMACY SERVICES	624	INVESTIGATIONAL DEVICE (IDE)
263	IV THERAPY/DRUG SUPPLY/DELIVERY	630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
264	IV THERAPY/SUPPLIES	631	SINGLE SOURCE
269	OTHER IV THERAPY	632	MULTIPLE
270	M&S SUPPLIES	633	RESTRICTIVE PRESCRIPTION
271	NONSTERILE SUPPLIES	700	CAST ROOM
272	STERILE SUPPLIES	709	OTHER CAST ROOM
274	PROSTHETIC/ORTHOTIC DEVICES	710	RECOVERY ROOM
275	PACEMAKER DRUG	719	OTHER RECOVERY ROOM
276	INTRAOCULAR LENS SOURCE DRUG	720	LABOR ROOM
278	OTHER IMPLANTS	721	LABOR
279	OTHER M&S SUPPLIES	819	OTHER ORGAN ACQUISITION
280	ONCOLOGY		
289	OTHER ONCOLOGY		
762	OBSERVATION ROOM		
810	ORGAN ACQUISITION		

MEDICAL VISIT

250	PHARMACY	630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
251	GENERIC		
252	NONGENERIC		

257	NONPRESCRIPTION DRUGS
258	IV SOLUTIONS
259	OTHER PHARMACY
270	M&S SUPPLIES
271	NONSTERILE SUPPLIES
272	STERILE SUPPLIES
279	OTHER M&S SUPPLIES
560	MEDICAL SOCIAL SERVICES
569	OTHER MEDICAL SOCIAL SERVICES
631	SINGLE SOURCE DRUG
632	MULTIPLE SOURCE DRUG
633	RESTRICTIVE PRESCRIPTION
637	SELF-ADMINISTERED DRUG (INSULIN ADMIN. IN EMERGENCY DIABETIC COMA
700	CAST ROOM
709	OTHER CAST ROOM
762	OBSERVATION ROOM
942	EDUCATION/TRAINING

OTHER DIAGNOSTIC

254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC
280	ONCOLOGY
289	OTHER ONCOLOGY
372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC
560	MEDICAL SOCIAL SERVICES
569	OTHER MEDICAL SOCIAL SERVICES
622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC
624	INVESTIGATIONAL DEVICE (IDE)
710	RECOVERY ROOM
719	OTHER RECOVERY ROOM
762	OBSERVATION ROOM

RADIOLOGY

255	PHARMACY INCIDENT TO RADIOLOGY
280	ONCOLOGY
289	OTHER ONCOLOGY
371	ANESTHESIA INCIDENT TO RADIOLOGY
560	MEDICAL SOCIAL SERVICES
710	RECOVERY ROOM
719	OTHER RECOVERY ROOM
569	OTHER MEDICAL SOCIAL SERVICES
621	SUPPLIES INCIDENT TO RADIOLOGY
624	INVESTIGATIONAL DEVICE (IDE)
762	OBSERVATION ROOM

ALL OTHER APC GROUPS

250	PHARMACY
251	GENERIC
271	NONSTERILE SUPPLIES
272	STERILE SUPPLIES

252	NONGENERIC
257	NONPRESCRIPTION DRUGS
258	IV SOLUTIONS
259	OTHER PHARMACY
260	IV THERAPY, GENERAL CLASS
262	IV THERAPY PHARMACY SERVICES
263	IV THERAPY DRUG/SUPPLY/DELIVERY
264	IV THERAPY SUPPLIES
269	OTHER IV THERAPY
270	M&S SUPPLIES
279	OTHER M&S SUPPLIES
560	MEDICAL SOCIAL SERVICES
569	OTHER MEDICAL SOCIAL SERVICES
630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
631	SINGLE SOURCE DRUG
632	MULTIPLE SOURCE DRUG
633	RESTRICTIVE PRESCRIPTION
762	OBSERVATION ROOM
942	EDUCATION/TRAINING

3. Limit on Variation of Costs of Services Classified Within a Group

Section 1833(t)(2) of the Act provides that the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest cost item or service within a group is more than 2 times greater than the lowest cost item or service within the same group, but the Secretary may make exceptions to this limit on the variation of costs within each group in unusual cases such as low volume items and services. No exception may be made, however, in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act.

Based on the proposed APC changes discussed above in this section of this preamble and the use of more current data to calculate the median cost of procedures classified to APCs, we reviewed all the APCs to determine which of them would not meet the 2 times limit. We use the following criteria when deciding whether to make exceptions to the 2 times rule for affected APCs:

- Resource homogeneity.
- Clinical homogeneity.

- Hospital concentration.
- Frequency of service (volume).
- Opportunity for upcoding and code fragmentation.

For a detailed discussion of these criteria, refer to the April 7, 2000 final rule (65 FR 18457).

The following list contains APCs that we propose to except from the 2 times rule based on the criteria cited above. In cases in which compliance with the 2 times rule appeared to conflict with a recommendation of the APC Advisory Panel, we generally accepted the Panel recommendation. This was because Panel recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine payment rates.

0001	Photochemotherapy
0041	Arthroscopy
0044	Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk
0047	Arthroplasty without Prosthesis
0058	Level I Strapping and Cast Application
0077	Level I Pulmonary Treatment
0093	Vascular Repair/Fistula Construction
0096	Noninvasive Vascular Studies
0097	Cardiac Monitoring for 30 days
0115	Cannula/Access Device Procedures
0121	Level I Tube Changes and Repositioning
0140	Esophageal Dilation without Endoscopy
0147	Level II Sigmoidoscopy
0164	Level I Urinary and Anal Procedures

0165	Level II Urinary and Anal Procedures
0182	Insertion of Penile Prosthesis
0198	Pregnancy and Neonatal Care Procedures
0203	Level V Nerve Injections
0204	Level VI Nerve Injections
0207	Level IV Nerve Injections
0213	Extended EEG Studies and Sleep Studies
0215	Level I Nerve and Muscle Tests
0231	Level II Eye Tests
0238	Level I Repair and Plastic Eye Procedures
0251	Level I ENT Procedures
0260	Level I Plain Film Except Teeth
0265	Level I Diagnostic Ultrasound Except Vascular
0279	Level I Angiography and Venography except Extremity
0285	Positron Emission Tomography (PET)
0305	Level II Therapeutic Radiation Preparation
0322	Brief Individual Psychotherapy
0345	Level I Transfusion Lab Procedures
0349	Miscellaneous Lab Procedures
0354	Administration of Influenza/Pneumonia Vaccine
0356	Level II Immunizations
0363	Otorhinolaryngologic Function Tests
0364	Level I Audiometry
0373	Neuropsychological Testing
0602	High Level Clinic Visits
0694	Level III Excision/Biopsy
0697	Level II Transesophageal Procedures

4. Observation Services

Observation services have a long intertwined clinical and payment history. For many years, beneficiaries have been placed in "observation status" in order to receive treatment or be monitored before making a decision concerning their next placement (that is, admit to the hospital or discharge to home). This occurs most

frequently after surgery or a visit to the emergency department. Typically, beneficiaries placed in observation have failed to respond to initial emergency department treatment for their condition (for example, exacerbation of asthma), have symptoms placing them at significant risk for mortality (for example, chest pains with the possibility of myocardial infarction), or have received anesthesia for a surgical procedure and need to be monitored postoperatively. Clinically, most beneficiaries do not require more than 24 hours of observation before a decision concerning admission or discharge can be made. Therefore, it is rare that it is clinically justifiable to keep a patient in observation for more than 24 to 48 hours. The location where observation services are provided is facility-specific, and sometimes individual-specific. It is not uncommon for beneficiaries to be observed in the emergency department, in a designated unit near the emergency department, or in an intensive care or other unit in the facility.

After implementation of the Medicare hospital inpatient PPS in 1983, peer review organizations (PROs) began to review inpatient admissions to determine whether

the admission and the length of stay were appropriate. Because "observation care" is considered to be an outpatient service, facilities began using "observation" as an administrative mechanism to care for beneficiaries who, if admitted as inpatients, might have their admission questioned by the PRO. Moreover, before the implementation of the OPPS, the payment for observation care was on a reasonable cost basis, which frequently gave hospitals a financial incentive to keep beneficiaries in "observation status" even though they were clinically being treated as inpatients. Occasionally, beneficiaries were kept in observation for days and weeks resulting in both excessive payments from the Medicare program and excessive copayments from the beneficiary. In response to this practice, Medicare revised its manuals in November 1996, limiting covered observation services to no more than 48 hours (section 456 of the Hospital Manual and section 3663 of the Intermediary Manual).

The costs for all observation services provided in the outpatient setting, even those provided in excess of 48 hours, were included in the initial APC payment rates. Currently, observation services are not paid separately,

that is, they are not assigned to a separate APC. Instead, costs for observation services are packaged into payments for services with which the observation was billed in 1996. Observation was most frequently billed with emergency department visits, clinic visits, and surgical procedures. The payments for all APCs include the costs of observation to the extent that it was billed in 1996. In the 1996 data, we identified and packaged a total of $392 million from revenue codes 760, 761, 762, and 769, which represented observation services.

In the April 7, 2000 final rule (65 FR 18448), we responded to numerous comments concerning observation services. Even though commenters acknowledged that being paid separately for observation services following a surgical procedure was unnecessary, many commenters requested that we pay separately for observation services following emergency department visits. Among those commenters requesting separate payment for observation, some requested separate payment for specific medical conditions, and others requested payment for all medical conditions. Some commenters provided articles and books

containing clinical research on the value and cost effectiveness of observation for certain patients. Although we did not decide to create a separate APC for observation services, we did include this topic in the agenda for our APC Panel, which met from February 27 to March 1, 2001. While individual Panel members agreed that use of observation services had been abused in the past by hospitals seeking to maximize payment, the Panel also agreed that observation services following clinic and emergency room visits should be paid separately. In addition, the Panel believed that observation following surgery should be packaged into the payment for the surgical procedure. The Panel did not dispute that the vast majority of patients are admitted to the hospital or discharged home from observation in less than 24 hours, and Panel members judged that a rule limiting separate payment to 24 hours of observation would be reasonable. The Panel also noted that because Medicare currently allows hospitals to report observation services up to 48 hours, hospital staff and coders would have to be educated were we to change the current standard.

Since the Panel meeting, we have reviewed all comments we have received on this issue. In determining whether we should pay separately for observation services, our primary concern is to ensure that Medicare beneficiaries have access to medically necessary observation care. We also want to ensure that payment be made only for beneficiaries actually receiving observation care, and that payment be restricted to clinically appropriate observation care. We paid particular attention to the Qualcare criteria (severity of illness and intensity of service criteria used by some insurance plans to determine whether it is appropriate for a patient to receive observation care) for observation services and to those comments providing medical evidence on the value and cost effectiveness of observation care. We also carefully considered logistical and administrative issues related to delivering observation care such as whether payment for emergency services should be bundled into observation services, the potential for overuse of the services, and the need for treatment guidelines. We also considered how to most appropriately define the starting time, discharge time, and minimum length of stay for observation care.

Finally, in considering whether to make a separate payment for observation care, we had to balance the issues of access, medical necessity, potential for abuse, and need to ensure appropriate payment. As a threshold requirement for candidate medical conditions, we sought published criteria regarding the following:

- Risk stratification of patients to determine which patient sub-populations benefit from observation care.
- Which patients should be admitted to observation.
- Which patients should be discharged home from observation.
- When patients should be admitted to the hospital from observation.
- Patient management.

We found that these criteria were met for chest pain, asthma, and congestive heart failure.

The fulfillment of these criteria ensured that, for these conditions, observation care avoided significant morbidity and mortality from inappropriate discharge to home while at the same time avoiding unnecessary inpatient admissions. For example, the use of observation for

selected patients with asthma and congestive heart failure can reduce the rate of return emergency visits and subsequent admission. The literature clearly shows that for these patients, observation care requires prolonged physiologic monitoring and intensive treatment to result in the beneficial outcomes.

After careful consideration, we are proposing--

- To continue to package observation services into surgical procedures; and
- To create a single APC, APC 0339, Observation, to make separate payment for observation services for three medical conditions, chest pain, asthma, and congestive heart failure, when certain criteria (as described below) are met.

We are further proposing to instruct hospitals that payment under APC 0339 for observation services would be subject to the following billing requirements and conditions:

- An emergency department visit (APC 0610, 0611, or 0612) or a clinic visit (APC 0600, 0601, or 0602) is billed in conjunction with each bill for observation services.

- Observation care is billed hourly for a minimum of 8 hours up to a maximum of 48 hours. We would not pay separately for any hours a beneficiary spends in observation over 24 hours, but all costs beyond 24 hours would be packaged into the APC payment for observation services.

- Observation time begins at the clock time appearing on the nurse's observation admission note. (We note that this coincides with the initiation of observation care or with the time of the patient's arrival in the observation unit.)

- Observation time ends at the clock time documented in the physician’s discharge orders, or, in the absence of such a documented time, the clock time when the nurse or other appropriate person signs off on the physician's discharge order. (This time coincides with the end of the patient's period of monitoring or treatment in observation.)

- The beneficiary is under the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other

appropriate progress notes, timed, written, and signed by the physician.

- The medical record includes documentation that the physician used risk stratification criteria to determine that the beneficiary would benefit from observation care. (These criteria may be either published generally accepted medical standards or established hospital-specific standards.)
- The hospital furnishes certain other diagnostic services along with observation services to ensure that separate payment is made only for those beneficiaries truly requiring observation care. We believe that these tests are typically performed on beneficiaries requiring observation care for the three specified conditions and they are medically necessary to determine whether a beneficiary will benefit from being admitted to observation care and the appropriate disposition of a patient in observation care. The diagnostic tests are as follows:
- For chest pain, at least two sets of cardiac enzymes and two sequential electrocardiograms.

- For asthma, a peak expiratory flow rate (PEFR) (CPT code 94010) and nebulizer treatments.

- For congestive heart failure, a chest x-ray, an electrocardiogram, and pulse oximetry.

We are proposing to make payment for APC 0339 only if the tests described above are billed on the same claim as the observation service.

(We are not proposing to require telemetry and other ongoing monitoring services as criteria to make separate payment for observation services. Although these services are often medically necessary to ensure prompt diagnosis of cardiac arrhythmias and other disorders, we do not believe they are necessary to support separate payment for observation services.)

We propose to require that, in order to receive payment for APC 0339, the hospital must include one of the ICD-9-CM diagnosis codes listed below in the diagnosis field of the bill. We propose the following diagnosis codes to indicate a symptom or condition that would require observation:

For Chest Pain:

411.1 Intermediate coronary syndrome

411.81 Coronary occlusion without myocardial infarction

411.0 Postmyocardial infarction syndrome

411.89 Other acute ischemic heart disease

413.0 Angina decubitus

413.1 Prinzmetal angina

413.9 Other and unspecified angina pectoris

786.05 Shortness of breath

786.50 Chest pain, unspecified

786.51 Precordial pain

786.52 Painful respiration

786.59 Other chest pain

For Asthma:

493.01 Extrinsic asthma with status asthmaticus

493.02 Extrinsic asthma with acute exacerbation

493.11 Intrinsic asthma with status asthmaticus

493.12 Intrinsic asthma with acute exacerbation

493.21 Chronic obstructive asthma with status asthmaticus

493.22 Chronic obstructive asthma with acute exacerbation

493.91 Asthma, unspecified with status asthmaticus

493.92 Asthma, unspecified with acute exacerbation

For Congestive Heart Failure:

428.0 Congestive heart failure

428.1 Left heart failure

428.9 Heart failure, unspecified

We used the following process to identify the appropriate median cost for APC 0339. First, we identified in the 1999-2000 claims data all hospital outpatient claims for observation using revenue codes 760, 761, 762, and 769. We then selected the subset of these claims that were billed for patients with chest pain, asthma, and congestive heart failure. Because no standard method for coding these claims was in place in 1996, we identified all diagnosis codes that could reasonably have been used to classify beneficiaries as having chest pain, asthma, and congestive heart failure. We then verified that these beneficiaries received appropriate observation care for chest pain, asthma, or congestive heart failure by identifying the claims in which one or more of the tests identified above were performed. The median costs of these claims were used to establish the median costs of APC 0339.

We appreciate that there are other medical conditions for which selected beneficiaries may benefit from observation care and we are interested in comments on whether we should make separate payment for observation care for other conditions. We will consider medical research submitted to support the benefits of observation services for these conditions. This information will assist us in determining whether these other conditions meet the criteria we used to select the three conditions we have proposed to include in APC 0339.

5. List of Procedures That Will Be Paid Only As Inpatient Procedures

Before implementation of the OPPS, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

Section 1833(t)(1)(B)(i) of the Social Security Act gave the Secretary broad authority to determine the services to be covered and paid for under the OPPS. In the September 8, 1998 OPPS proposed rule, we defined a set of services that are typically provided only in an inpatient setting and, hence, would not be paid by Medicare under the OPPS. This set of services is referred to as the "inpatient list."

We received numerous comments on the inpatient list. In the April 7, 2000 final rule, we revised the proposed list by removing a number of services and we discussed in greater detail the criteria we will use to define which services will be included on the inpatient list (65 FR 18455). These are services that require inpatient care because of the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient.

After publication of the April 7 final rule, we received information from a number of groups demonstrating that certain services are routinely provided safely in the outpatient setting. As a result, in the November 13, 2000

interim final rule, we removed 44 procedures from the list (65 FR 67826). In that rule, we also stated that we would update the list at least quarterly to reflect advances in medical practice that permit procedures to be routinely performed in the outpatient setting. And, on June 1, 2001, we issued Program Memorandum A-01-73 in which we moved an additional 23 procedures from the inpatient list.

At its February 2001 meeting, the APC Advisory Panel discussed the existence of the inpatient list. The Advisory Panel generally favored its elimination. In this instance, we disagree with the position taken by the Panel. Rather, we propose to continue the current policy of reviewing the HCPCS codes on the inpatient list and eliminating procedures from the list if they can be appropriately performed on the Medicare population in the outpatient setting. Our medical and policy staff, supplemented as appropriate by the APC Advisory Panel, would review comments submitted by the public and consider advances in medical practice in making decisions to remove codes from the list. We would continue to use the following criteria, which we discussed in the April 7, 2000 final rule, when deciding to remove codes from the list:

- Most outpatient departments are equipped to provide the services to the Medicare population.

- The simplest procedure described by the code may be performed in most outpatient departments.

- The procedure is related to codes we have already moved off the inpatient list (for example, the radiologic part of an interventional cardiology procedure).

We would continue to update the list in response to comments as often as quarterly through program memoranda to reflect current advances in medical practice. We believe that the current list addresses the concerns of previous commenters and reflects a general consensus about those services that hospitals and physicians agree are not routinely performed in the outpatient setting. Therefore, at this time, we are proposing no further changes to the inpatient list, which is set forth in Addendum E to this proposed rule.

6. Additional New Technology APC Groups

In the April 7, 2000 final rule, we created 15 new technology APC groups to pay for new technologies that do not meet the statutory requirements for transitional pass-

through payments and for which we have little or no data upon which to base assignment to an appropriate APC. APC groups 0970 through 0984 are the current new technology APCs. We currently assign services to a new technology APC for 2 to 3 years based solely on costs, without regard to clinical factors. This method of paying for new technologies allows us to gather data on their use for subsequent assignment to a clinically-based APC. Payment rates for the new technology APCs are based on the midpoint of ranges of possible costs.

After evaluating the costs of services in the new technology APCs, we are proposing that APC 0982, which covers a range of costs from $2500 to $3500, be split into two APCs, as follows: APC 0982, which would encompass services whose costs fall between $2500 and $3000, and APC 0983, which would encompass those services whose costs fall between $3000 and $3500. APC 0984 would then encompass services whose costs fall between $3500 and $5000 and we would create a new APC, 0985, for services whose costs fall between $5000 and $6000. We believe that subdividing the current range of costs within APC 0982 would allow us to pay more accurately for the services in that cost range.

In section VI.G of this preamble, we describe several modifications and refinements to the criteria and process for assigning services to new technology APCs that we are proposing in this rule.

Table 3 below, lists all of the APC groups that we are proposing to change for 2002.

Table 3--APC Groups Proposed To Be Changed in 2002

APC	Title	SI	APC Panel	2 Times	Other
0002	Fine needle Biopsy/Aspiration	T		X	
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T		X	
0006	Level I Incision & Drainage	T		X	
0007	Level II Incision & Drainage	T		X	
0008	Level III Incision & Drainage	T		X	
0012	Level I Debridement & Destruction	T		X	
0013	Level II Debridement & Destruction	T		X	
0014	Level III Debridement and Destruction	T		X	
0015	Level IV Debridement & Destruction	T		X	
0016	Level V Debridement & Destruction	T	X	X	
0017	Level VI Debridement & Destruction	T	X	X	
0018	Biopsy of Skin/Puncture of Lesion	T		X	
0019	Level I Excision/ Biopsy	T		X	
0020	Level II Excision/ Biopsy	T		X	
0021	Level IV Excision/ Biopsy	T		X	
0022	Level V Excision/ Biopsy	T		X	
0026	Level III Skin Repair	T		X	

0027	Level IV Skin Repair	T		X	
0029	Level II Incision/Excision Breast	T		X	
0030	Level I Breast Reconstruction	T		X	
0032	Insertion of Central Venous/Arterial Catheter	T		X	
0035	Placement of Arterial/Central Venous Catheter	T		X	
0043	Closed Treatment Fracture Finger/Toe/Trunk	T		X	
0044	Closed Treatment Fracture/Dislocation except Finger/Toe/Trunk	T		X	
0045	Bone/Joint Manipulation Under Anesthesia	T		X	
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T		X	
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T		X	
0058	Level I Strapping and Cast Application	S		X	
0059	Level II Strapping and Cast Application	S		X	
0068	CPAP Initiation	S	X		
0069	Thoracoscopy	T		X	
0074	Level IV Endoscopy Upper Airway	T		X	
0075	Level V Endoscopy	T		X	

	Upper Airway				
0076	Endoscopy Lower Airway	T		X	
0079	Ventilation Initiation and Management	S	X		
0082	Coronary Atherectomy	T		X	
0083	Coronary Angioplasty	T		X	
0087	Cardiac Electrophysiologic Recording/Mapping	S	X		
0088	Thrombectomy	T		X	
0093	Vascular Repair/Fistula Construction	T		X	
0094	Resuscitation and Cardioversion	S	X		
0097	Cardiac Monitoring for 30 days	T		X	
0102	Electronic Analysis of Pacemakers/other Devices	S	X		
0105	Revision/Removal of Pacemakers, AICD, or Vascular Device	T	X		
0111	Blood Product Exchange	S	X		
0112	Apheresis, Photopheresis, and Plasmapheresis	S	X		
0115	Cannula/Access Device Procedures	T		X	
0125	Refilling of Infusion Pump	T	X		
0130	Level I Laparoscopy	T		X	
0131	Level II Laparoscopy	T		X	
0148	Level I Anal/Rectal Procedure	T		X	
0149	Level III Anal/Rectal Procedure	T		X	
0150	Level IV Anal/Rectal	T		X	

	Procedure				
0155	Level II Anal/Rectal Procedure	T		X	
0156	Level II Urinary and Anal Procedures	T		X	
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T		X	
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T		X	
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T		X	
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T		X	
0164	Level I Urinary and Anal Procedures	T		X	
0165	Level III Urinary and Anal Procedures	T		X	
0188	Level II Female Reproductive Proc	T	X	X	
0189	Level III Female Reproductive Proc	T	X	X	
0191	Level I Female Reproductive Proc	T	X	X	
0192	Level IV Female Reproductive Proc	T	X	X	
0193	Level V Female Reproductive Proc	T	X	X	
0194	Level VI Female Reproductive Proc	T	X	X	
0195	Level VII Female	T	X	X	

	Reproductive Proc				
0196	Dilation and Curettage	T		X	
0203	Level V Nerve Injections	T	X		
0204	Level VI Nerve Injections	T	X		
0206	Level III Nerve Injections	T	X		
0207	Level IV Nerve Injections	T	X		
0208	Laminotomies and Laminectomies	T	X		
0209	Level II Extended EEG Studies and Sleep Studies	S		X	
0212	Level II Nervous System Injections	T	X		
0213	Level I Extended EEG Studies and Sleep Studies	S		X	
0215	Level I Nerve and Muscle Tests	S	X	X	
0216	Level III Nerve and Muscle Tests	S	X	X	
0217	Level III Nerve and Muscle Tests	S		X	
0218	Level II Nerve and Muscle Tests	S		X	
0230	Level I Eye Tests & Treatments	S		X	X
0231	Level III Eye Tests & Treatments	S		X	
0232	Level I Anterior Segment Eye	S		X	
0233	Level II Anterior Segment Eye	T		X	
0234	Level III Anterior Segment Eye Procedures	T		X	
0235	Level I Posterior Segment Eye	T		X	

	Procedures				
0236	Level II Posterior Segment Eye Procedures	T		X	
0237	Level III Posterior Segment Eye Procedures	T		X	
0238	Level I Repair and Plastic Eye Procedures	T		X	
0239	Level II Repair and Plastic Eye Procedures	T		X	
0245	Level I Cataract Procedures without IOL Insert	T		X	
0249	Level II Cataract Procedures without IOL Insert	T		X	
0251	Level I ENT Procedures	T		X	
0252	Level II ENT Procedures	T		X	
0253	Level III ENT Procedures	T		X	
0254	Level IV ENT Procedures	T		X	
0256	Level V ENT Procedures	T		X	
0259	Level VI ENT Procedures	T		X	
0260	Level I Plain Film Except Teeth	X		X	
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X		X	
0263	Level I Miscellaneous Radiology Procedures	X		X	
0264	Level II Miscellaneous	X		X	

	Radiology Procedures				
0265	Level I Diagnostic Ultrasound Except Vascular	X		X	
0266	Level II Diagnostic Ultrasound Except Vascular	S		X	
0269	Level I Echocardiogram Except Transesophageal	S		X	
0271	Mammography	S			X
0272	Level I Fluoroscopy	X		X	
0279	Level I Angiography and Venography except Extremity	S	X		
0280	Level II Angiography and Venography	S	X		
0282	Miscellaneous Computerized Axial Tomography	S		X	X
0283	Computerized Axial Tomography with Contrast	S			X
0284	Magnetic Resonance Imaging and Angiography with Contrast	S			X
0287	Complex Venography	S	X		
0288	CT, Bone Density	S		X	
0289	Needle Localization for Breast Biopsy	X	X		
0291	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S		X	
0292	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S		X	
0300	Level I Radiation Therapy	S		X	

0301	Level II Radiation Therapy	S		X	
0302	Level III Radiation Therapy	S		X	
0304	Level I Therapeutic Radiation Treatment Preparation	X	X		
0305	Level II Therapeutic Radiation Treatment Preparation	X	X		
0312	Radioelement Applications	S	X		
0332	Computerized Axial Tomography w/o Contrast	S		X	X
0333	CT Angio and Computerized Axial Tomography w/o Contrast followed by with Contrast	S		X	X
0335	Magnetic Resonance Imaging, Temporomandular Joint	S			X
0336	Magnetic Resonance Angiography and Imaging without Contrast	S		X	X
0337	Magnetic Resonance Imaging and Angiography w/o Contrast followed by with Contrast	S			X
0338	Magnetic Resonance Angiography, Chest and Abdomen with or w/o Contrast	S			X
0339	Observation	X	X		
0340	Minor Ancillary Procedures	X		X	
0345	Level I Transfusion Laboratory	X		X	

	Procedures				
0346	Level II Transfusion Laboratory Procedures	X		X	
0347	Level III Transfusion Laboratory Procedures	X		X	
0352	Level II Injections	X		X	
0353	Level II Allergy Injections	X	X		
0355	Level I Immunizations	K		X	
0356	Level II Immunizations	K		X	
0359	Level I Injections	K		X	
0360	Level I Alimentary Tests	X		X	
0361	Level II Alimentary Tests	X		X	
0364	Level I Audiometry	X		X	
0365	Level II Audiometry	X		X	
0367	Level I Pulmonary Test	X		X	
0368	Level II Pulmonary Tests	X		X	
0369	Level III Pulmonary Tests	X		X	
0371	Level I Allergy Injections	X	X		
0689	Electronic Analysis of Cardioverter-Defibrillators	S	X		
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	X		
0691	Electronic Analysis of Programmable Shunts/Pumps	S	X		
0692	Electronic Analysis of Neurostimulator	S	X		

	Pulse Generators				
0693	Level II Breast Reconstruction	T		X	
0694	Level III Excision/Biopsy	T		X	
0695	Level VII Debridement & Destruction	T		X	
0696	Repair/Replacement of Cardioverter-Defibrillators	T	X		
0697	Level II Echocardiogram Except Transesophageal	S		X	
0698	Level II Eye Tests & Treatments	S		X	
0699	Level IV Eye Tests & Treatment	T		X	
0982	New Technology—Level XII ($2500-3000)	T			X
0983	New Technology-Level XIV ($3000-3500)	T			X
0984	New Technology-Level XV ($3500-5000)	T			X
0985	New Technology-Level XVI ($5000-6000)	T			X

D. Recalibration of APC Weights for CY 2002

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually beginning in 2001 for application in 2002. In the April 7, 2000 final rule (65 FR 18482), we explained in detail how we calculated the relative payment weights that were implemented on August 1,

2000 for each APC group. Except for some reweighting due to APC changes, these relative weights continued to be in effect for 2001. (See the November 13, 2000 interim final rule (65 FR 67824-67827).)

To recalibrate the relative APC weights for services furnished on or after January 1, 2002 and before January 1, 2003, we are proposing to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the relative weights for 2002. That is, we would recalibrate the weights based on claims and cost report data for outpatient services. We propose to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative weights for 2002, the most recent available claims data are the approximately 98 million final action claims for hospital outpatient department services furnished on or after July 1, 1999 and before July 1, 2000. We matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. The APC relative weights would continue to be based on the median hospital costs for services in the APC groups.

The methodology we followed to calculate the APC relative weights proposed for CY 2002 is as follows:

- We excluded from the data approximately 15.4 million claims for those bill and claim types that would not be paid under the OPPS (for example, bill type 72X for dialysis services for patients with ESRD).

- Using the most recent available cost report from each hospital, we converted billed charges to costs and aggregated them to the procedure or visit level first by identifying the cost-to-charge ratio specific to each hospital's cost centers ("cost center specific cost-to-charge ratios" or CCRs) and then by matching the CCRs to revenue centers used on the hospital's 1999-2000 outpatient bills. The CCRs included operating and capital costs but excluded costs paid on a reasonable cost basis that are described elsewhere of this preamble.

- We eliminated from the hospital CCR data 283 hospitals that we identified as having reported charges on their cost reports that were not actual charges (for example, they make uniform charges for all services).

- We calculated the geometric mean of the total operating CCRs of hospitals remaining in the CCR data. We

removed from the CCR data 67 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations.

- We excluded from our data approximately 1.8 million claims from the hospitals that we removed or trimmed from the hospital CCR data.

- We matched revenue centers from the remaining universe of approximately 80.8 million claims to CCRs of 5,653 hospitals.

- We separated the 80.8 million claims that we had matched with a cost report into two distinct groups: single-procedure claims and multiple-procedure claims. Single-procedure claims were those that included only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims included more than one HCPCS code that could be mapped to an APC. There were approximately 36.4 million single-procedure claims and 44.4 million multiple-procedure claims.

- To calculate median costs for services within an APC, we used only single-procedure bills. We did not use multiple-procedure claims because we are not able to

specifically allocate charges or costs for packaged items and services such as anesthesia, recovery room, drugs, or supplies to a particular procedure when more than one significant procedure or medical visit is billed on a claim. Use of the single-procedure bills minimizes the risk of improperly assigning costs to the wrong procedure or visit.

- For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. If the appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or to the hospital's overall cost-to-charge ratio for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under the OPPS (for example, laboratory, ambulance, and therapy services).

- To calculate the per-service costs, we used the charges shown in the revenue centers that contained items integral to performing the service. These included those items that we previously discussed as being subject to our

proposed packaging provision. For instance, in calculating the surgical procedure cost, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and organ. For medical visit cost estimates, we included charges for items such as medical and surgical supplies, drugs, and observation in those instances where it is still packaged. See sections II.C.1 and II.C.2 of this preamble for a discussion and complete listing of the revenue centers that we are proposing to use to calculate per-service costs.

- We standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the current FY 2001 hospital inpatient prospective payment system wage index published in the **Federal Register** on August 1, 2000 (65 FR 47054). We used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. A more detailed discussion of wage index adjustments is found in section III of this preamble.

- We summed the standardized labor-related cost and the nonlabor-related cost component for each billed item to

derive the total standardized cost for each procedure or medical visit.

- We removed extremely unusual costs that appeared to be errors in the data using a trimming methodology analogous to what we use in calculating the DRG weights for the hospital inpatient PPS. That is, we eliminated any bills with costs outside of 3 standard deviations from the geometric mean.

- After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC, including, to the extent possible, the proposed APC changes described elsewhere in this preamble.

- We calculated the median cost, weighted by procedure volume, for each APC.

- Using the weighted median APC costs, we calculated the relative payment weights for each APC. We scaled all the relative payment weights to APC 0601, Mid-level clinic visit, because it is one of the most frequently performed services in the hospital outpatient setting. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. We assigned APC 0601 a relative payment weight of 1.00 and divided the

median cost for each APC by the median cost for APC 0601, to derive the relative payment weight for each APC. The median cost for APC 0601 is $54.00.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes and wage index changes be made in a manner that assures that aggregate payments under the OPPS for 2002 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2001 relative weights to aggregate payments using the CY 2002 proposed weights. Based on this comparison, we are proposing to make an adjustment of 1.022 to the weights. The weights that we are proposing for 2002, which incorporate the recalibration adjustments explained in this section, are listed in Addendum A and Addendum B.